The District School Board of Collier County
Information Exchange Authorization - Educational / Medical / Health

Sec I. Student Informations

Student Name: Date of Birth:

Student ID: Grade: Teacher:

Sec II. School Information

School Name: Collier County Public Schools/ Phone:

School Address: City: State FL Zip

School Contact: Title:

Email: Fax:

Sec. Ill Provider/Agency to Receive or Release Information

Name of Provider/Agency:

Address: City: State FL Zip

Profession:

Phone: Ext: Fax:

Email:

Sec. IV Information to be Exchanged Indicates whether to Receive and/or Release

	Information to exchange	*Receive*	*Release*			*Information to exchange*	*Receive*	*Release*
☐	Academic Records	☐	☐		☐	Physical Therapy Evaluations	☐	☐
☐	EP -Education Plan (Gifted)	☐	☐		☐	Positive Behavior Intervention Plan	☐	☐
☐	Functional Behavior Assessment	☐	☐		☐	Psychological Reports	☐	☐
☐	IEP-Individual Education Plan (ESE)	☐	☐		☐	Section 504 Records	☐	☐
☐	IHP-Individual Health Plan	☐	☐		☐	Standardized Test Scores	☐	☐
☐	Immunization Records	☐	☐		☐	Speech Language Evaluations	☐	☐
☐	Occupational Therapy Report	☐	☐		☐	Teacher Ratings/Observations	☐	☐
☐	Verbal Communication	☐	☐		☐	Official School Transcript	☐	☐
☐	**Medical/Health*Specified below**	☐	☐		☐		☐	☐

Other *Specify

Sec V. Purpose for this request:

☐ Educational Planning

☐ For provision of health-related services

☐ Other - Specify

Sec. VI Parent/Guardian Information & Consent

Parent/Guardian Name: Relationship:

Cell Phone: Phone (other):

I, _____, authorize Collier County Public Schools to exchange my child's educational, health, and/or medical Information as designated in Sec (IV). I am aware that the information will be held in strict confidence and will be used to evaluate and plan for my child's educational, medical, and/or health services and interventions. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the Provider/Agency from which the information was being requested from. I understand that the revocation will not apply to the information that has already been released in response to this authorization**. Unless otherwise revoked, this authorization to release any educational/medical information will be ongoing from the following dates from _____ till _____ (expiration date).**

_____ _____

Signature of Patient/Parent/Guardian Date

Information security and confidentiality are matters of serious concern for all persons who have access to student education, health, and medical records. The information contained in a student 's "educational records " is protected by the Family Educational Rights and Privacy Act (FERPAO of1974(20U.S C. 123g(a)). The Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule (Code of Federal Regulations, Title 45, Part 164) governs how "covered entities " may use and disclose "protected health information ". The Federal Family Rights and Privacy Act does not require parent permission for sending records to a school to which a student is transferring. In such case no parent authorization may appear here.